

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495258	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED C 01/10/2018
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF SUFFOLK			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 PRUDEN BOULEVARD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>Description of structure: One Story with a construction type of type II(000)</p> <p>Sprinkler status: Fully sprinklered in accordance with NFPA-13</p> <p>An unannounced complaint Life Safety Code survey was conducted 01/10/18 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid.</p> <p>On 01/07/18 Facility reported a leaking pipe to the sprinkler system. Facility reported they are waiting on Fire Safety Company to repair. No other details provided.</p> <p>On 1/8/18 Follow up revealed break occurred due to water freezing. Break was repaired, however system cannot be flushed and recharged until ambient temperature rises and stays above freezing. Facility remains on fire watch until system fully restored.</p> <p>Findings include:</p> <p>On 01/10/18 between 9:00 AM and 9:30 AM it was observed that the leaking pipe to the sprinkler system had been temporary repaired and facility continues with fire watch.</p> <p>On 01/12/18 a permanent repair was completed by BFPE International Fire Safety, sprinkler</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 system back online and fire watch terminated. No deficiency noted, the above was observed by the Director of Maintenance and the Facility Administrator.	K 000			